APPEAL NO. 93400

This appeal arises under the Texas Workers' Compensation Act, TEX. REV. CIV. STAT. ANN. art. 8303-1.01 *et seq.* (Vernon Supp. 1993) (1989 Act). A contested case hearing with (hearing officer) presiding was opened in (city), Texas, on March 31, 1993, and the record was closed on April 7, 1993. The issue at the hearing was whether the respondent (claimant herein) had reached maximum medical improvement (MMI); and if so, what was the correct impairment rating, if any. The hearing officer found that the claimant had reached MMI April 6, 1993, by operation of Article 8308-1.03(32) (1989 Act), and ordered the claimant to submit to an examination of a doctor selected by the Texas Workers' Compensation Commission (Commission) pursuant to Article 8308-4.16(a) to determine her impairment rating.

The appellant (carrier herein) argues in its request for review that the hearing officer failed to give the report of the designated doctor, who found the claimant had reached MMI on June 1, 1992, with a zero percent impairment, presumptive weight. The carrier contends that the conclusions of the designated doctor are not against the great weight of the other medical evidence, but in fact supported by it. The claimant files no response to the carrier's request for review.

DECISION

Finding no reversible error and the decision of the hearing officer not to be against the great weight and preponderance of the evidence, we affirm.

It was undisputed that the claimant was injured on (date of injury), during the course and in the scope of her employment, while lifting boxes. The claimant testified that she was originally treated by a (Dr. E). Dr. E ordered an MRI of the lumbar spine which was performed on August 31, 1991, and the report of which indicated no evidence of disc herniation and "normal MRI of the lumbar spine," but noted "[p]atient motion artifacts obscure detail." The claimant testified that she last saw Dr. E on September 5, 1991.

The claimant testified that she and her previous attorney came to the Commission and agreed that she would be treated by (Dr. M). After the parties received information that Dr. M was no longer treating lower backs and after some further discussion between the parties, the claimant testified she began treating with (Dr. A), an orthopedic and hand surgeon. In his report of November 20, 1991, Dr. A described his physical exam of November 15, 1992, of the claimant and diagnosed low back syndrome stating that x-rays of the lumbosacral back were normal. He ordered a myelogram and expressed the opinion that if the myelogram was normal he would feel that the claimant should return to work in her normal occupation. On February 5, 1992, on a Report of Medical Evaluation (TWCC-69) Dr. A certified that the claimant had reached MMI on February 5, 1992, with a zero impairment rating. On a disability insurance claim form dated June 19, 1992, Dr. A stated that the patient is disabled from working from "11-15-91 thru undetermined."

In a Request for Setting a Benefit Review Conference (request) filed in the case by the claimant's attorney dated March 4, 1992, it is stated that the claimant was dissatisfied with Dr. A's treatment and that while she had been informed by him that he was going to schedule a myelogram, she was never advised of the date it was scheduled and consequently missed the myelogram. It is further stated in the request that Dr. A then "released [the claimant] to return to work with a zero impairment rating" without the myelogram having been performed.

On April 2, 1992, a lumbar myelogram was performed with Dr. A listed as the requesting physician. The radiology report of this myelogram stated, "[t]he exam is mildly insensitive at the L4-5 and L5-S1 level due to a slightly prominent anterior epidural space at those levels," but stated "essentially negative examination". A radiology report of a post-myelogram CT scan of the lumbar spine also dated April 2, 1992, stated:

> At the L-3 level, I believe there is minimal diffuse posterior annular bulge. There is a small amount of extradural contrast in the spinal canal posterior to the thecal sac at the at the L3-4 level. There is mild facet hypertrophic change of the superior articular facets at L3-4. At L4-5, a minimal posterior annular bulge is noted with minimal facet hypertrophic change. At L5-S1, a minimal posterior annular bulge in the midline, a little asymmetrical towards the left side.

This report concluded "no evidence of disc herniation" and "mild facet hypertrophic change is present."

Two notices dated June 2, 1992, were sent by the Commission to the claimant. One notice indicated that since the Commission had received a notice of dispute of MMI or impairment rating the claimant should contact the carrier to see if an agreement could be reached upon another doctor for an evaluation, and stated if there was no agreement then the Commission would designate a doctor. The second notice informed the claimant that her request to approve (Dr. H) as her treating doctor had been granted.

On June 9, 1992, there was an MRI of the lumbar spine performed with Dr. H listed as the requesting physician. The radiology report from this exam stated:

> At L4-5 there is a focal 2-3mm disc herniation which touches and barely effaces the anterior aspect of the thecal sac at the level of the exit of the L4 nerve roots. There is no definite evidence for compromise of the neuro-foramen or lateral recesses, however.
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> At L5-S1 there is a 1-2mm minimal central broader based disc bulge into the anterior pre-thecal epidural fat which does not touch the thecal sac due to increased

pre-thecal epidural space at this level. There is also evidence for a small centrally located prominent venous plexus at this level.

On June 23, 1992, the Commission designated (Dr. O) to be the claimant's designated doctor. On July 5, 1992, the claimant was admitted into the hospital with the diagnosis of ruptured right tubal ectopic pregnancy and anemia secondary to blood loss and under general anesthesia underwent a laparotomy. She was discharged from the hospital on July 11, 1992, and advised to remain on light activity. On July 24, 1992, at the direction of Dr. O the claimant underwent range of motion studies apparently supervised by a (Dr. B). Dr. B's report showed he was aware of the scar in the claimant's lower abdomen from the surgery of July 5, 1992, and he noted extreme tenderness on palpitation of the that general region. The claimant testified at the hearing that she had stated to the examiner that she was unable to perform many of the requested motions because of her recent surgery, but was told that it would not make any difference in conducting her range of motion studies. In his report of August 14, 1992, Dr. O invalidates the claimant's range of motion studies because "she did not have the proper relationship between the true lumbar flexion and the hip movement." In his report Dr. O states that this "was a very confusing case in which the patient had had a normal lumbar myelogram, however, an MRI had been read showing a disc." Dr. O stated that he had all the films, including the MRI, myelogram and discogram sent to a Dr. Knight who read all of them as normal. In any case he felt that the claimant had reached maximum medical improvement on June 1, 1992, with a zero impairment and so certified on a TWCC-69.

On October 21, 1992, Dr. H wrote to the Commission stating that he had reviewed Dr. O's report and disagreed with his opinion that the claimant had reached MMI. He criticized the methodology of Dr. O's examination and enclosed medical articles in support of his position.

On December 7, 1992, the Commission wrote to Dr. O and sent him medical reports concerning claimant's July 1992 hospitalization and surgery and asked if review of these reports affected his opinion as to MMI. Dr. O stated in his reply of December 11, 1992, "a tubal pregnancy does not have anything to do with any traumatic injury" and further said "this would not change my original impairment rating for this patient."

In March 1992 the claimant underwent a three dimensional discogram (3D discogram) which was admitted into evidence at the hearing over the objection of the carrier. Dr. H explained at the hearing that this 3D discogram showed near to the dye, which for purposes of contrast had been made green, that one could see what looked to be a cavity in the disc. He went on to testify that the 3D discography shows an annular tear which has not extended into the inner most fibers bordering the nucleus. He stated that this showed a structural disruption of the disc which would only show somewhat subtly on other tests but was brought out clearly on the 3D discogram. Dr. H stated that this problem required

surgical correction and therefore he did not believe that the claimant had reached MMI.

Dr. H further testified that Dr. O's statement that conducting the range of motion testing only days after claimant's surgery did not make any difference was incorrect. He further criticized Dr. O's use of Manser's test and Waddell's test to invalidate the range of motion study, stating that this is not a proper reason under the AMA Guides to the Evaluation of Permanent Imapirment (AMA Guides) to invalidate a range of motion study.

There is a great deal of conflicting and sometimes confusing medical evidence in this case. Article 8308-6.34(e) provides that the contested case hearing officer, as finder of fact, is the sole judge of the relevance and materiality of the evidence, as well as the weight and credibility that is to be given the evidence. It was for the hearing officer, as trier of fact, to resolve the inconsistencies and conflicts in the evidence. Garza v. Commercial Insurance Company of Newark, New Jersey, 508 S.W.2d 701 (Tex. Civ. App.-Amarillo 1974, no writ). This is equally true regarding medical evidence. Texas Employers Insurance Association v. Campos, 666 S.W.2d 286 (Tex. App.-Houston [14th Dist.] 1984, no writ). An appeals level body is not a fact finder, and does not normally pass upon the credibility of witnesses or substitute its own judgment for that of the trier of fact, even if the evidence would support a different result. National Union Fire Insurance Company of Pittsburgh, Pennsylvania v. Soto, 819 S.W.2d 619 (Tex App.- El Paso 1991, writ denied). When reviewing a hearing officer's decision for factual sufficiency of the evidence we should reverse such decision only if it is so contrary to the overwhelming weight of the evidence as to be clearly wrong and unjust. In re King's Estate, 150 Tex. 662, 244 S.W.2d 660 (1951); Pool v. Ford Motor Co., 715 S.W.2d 629,635 (Tex. 1986).

We are not, however, unmindful of our responsibility to enforce the legal standard found in Article 8308-4.25(b) that the opinion of the designated doctor in regard to MMI is to be given presumptive weight unless overcome by the great weight of the other medical evidence. We have shown our determination to enforce this standard in past cases. *See* Texas Workers' Compensation Commission Appeals No. 92412, decided September 28, 1992; Texas Workers' Compensation Commission Appeals No. 93295, decided June 2, 1993.

Any determination of a case which turns upon factual considerations is by definition limited to the facts of the particular case. In this particular case we feel that there is sufficient evidence to support the findings of the hearing officer. Her findings were supported by the testimony of Dr. H which explained the significance of the 3D discogram showing an objective disruption of the claimant's disc which in his opinion required surgical repair and which precluded her having reached MMI. The testimony of Dr. H explained in detail why the designated doctor as well as the claimant's previous treating doctor, Dr. A, were unable to diagnose this disc disruption based upon the tests they had reviewed. Also the findings of the hearing officer are supported by the physical photographs from the 3D

discogram which are in evidence; the testimony of the claimant concerning her physical condition and symptoms; the failure of Dr. A to reference his opinion to any of the objective tests performed, and in fact his ordering of a myelogram to determine MMI and then making a determination without its results, and the inconsistencies in his written reports; the indication of uncertainty of the designated doctor concerning whether or not the objective tests showed a herniated disc; and the fact designated doctor found his range of motion studies invalid even though they were performed so shortly after the claimant's surgery.

Carrier argues that "[e]ven if the carrier concedes that this diagnostic test [3D discogram] suggested disc disruption and mechanical instability, This (sic) evidence does not rise to meet the standard of the great weight of medical evidence to overcome the findings of the designated doctor." We do not base our decision to uphold the hearing officer solely upon this test, although it is persuasive evidence uncontradicted by the carrier, but upon the totality of the evidence before the hearing officer.

For the foregoing reasons the hearing officer is affirmed.

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Gary L. Kilgore
Appeals Judge

CONCUR:

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Stark O. Sanders, Jr.
Chief Appeals Judge

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Robert W. Potts
Appeals Judge